

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18&21 Film G193 3-13-56 ams

01811

CERTIFICATE OF DEATH

• 1825

Reg. Dist. No. 185-

1. PLACE OF DEATH

COUNTY Harford
 CITY (If outside corporate limits, write RURAL
OR
give nearest town)
 TOWN Havre de Grace

MARYLAND
 LENGTH OF STAY
(in this place)
2Mens - 5days

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS
Harford Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN Perryman

STREET
ADDRESS
Maple Ave

**3. NAME OF
DECEASED
(Type or Print)**

(First) Ralph (Middle) William (Last) Ashford

**4. DATE
OF
DEATH**

Feb. 23 1956

(Month) (Day) (Year)

5. SEX Male 6. COLOR OR
RACE White 7. SINGLE, MARRIED,
WIDOWED, DIVORCED
(Specify) Single 8. DATE OF BIRTH
Sept 1- 1934 9. AGE last birthday
21 yrs.
IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) Tay Laborer

10b. KIND OF BUSINESS
OR INDUSTRY Heating Business 11. BIRTHPLACE (State or foreign country) Va. 12. CITIZEN OF WHAT
COUNTRY? US

13. FATHER'S NAME

William Franklin Ashford

14. MOTHER'S MAIDEN NAME

Gelie Elizabeth Shrader

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

218-32-6941

17. INFORMANT & ADDRESS

Wm. F. Ashford. Perryman Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**825X IMMEDIATE CAUSE**

(A)

Brain stem damage

ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)

Spine fracture

Accident, Auto

INTERVAL BETWEEN
ONSET AND DEATH

2 mos.

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.****19a. DATE OF OPERATION****19b. MAJOR FINDINGS OF OPERATION**INTERVAL BETWEEN
ONSET AND DEATHYES NO

21c. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)
Highway

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

Cresswell, Rt #543

21d. TIME OF INJURY

(Month) (Day) (Year) (Hour)

12/18/55

21e. INJURY OCCURRED

White Not white
at work at work

21f. HOW DID INJURY OCCUR?

Automobile accident

22. I hereby certify that I attended the deceased from Dec. 18, 1955, to Feb. 23, 1956, that I last saw the deceased
alive on Feb. 23, 1956, end that death occurred at 12:05 A.M. from the causes and on the date stated above.

SIGNATURE

Wm. F. Shrader
23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

Feb. 26-1956.

NAME OF CEMETERY OR CREMATORIUM

Bakers Cemetery

LOCATION (City, town, or county)

aberdeen Md.

(State)

24. REC'D BY REGISTRAR**REGISTRAR'S SIGNATURE**

A. L. Lewis et al

25. FUNERAL DIRECTOR'S SIGNATURE

John G. Tarrington aberdeen Md.

BY THE GOVERNOR OF THE STATE OF CALIFORNIA

RECEIPT OF DEATH

BUREAU Y.

FEB 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

3478 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

01812

Reg. Dist. No. 185

1. PLACE OF DEATH COUNTY <i>Baltimore</i>		2. DAILY RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Baltimore</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	
LENGTH OF STAY (In this place) <i>70 yrs.</i>		STREET ADDRESS <i>Seneca Way</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		4. DATE OF DEATH <i>2/27/56</i>	
3. NAME OF DECEASED (Type or Print) <i>Willie Barfield</i>		5. SEX <i>Male</i>	
6. COLOR OR RACE <i>Negro</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	
8. DATE OF BIRTH <i>5/13/1902</i>		9. AGE last birthday If under 1 year Months Days Hours Min. <i>53 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cabby, Hand</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cabby, Hand</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Willie Barfield</i>		14. MOTHER'S MAIDEN NAME <i>Sophie ? Barfield</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT AND ADDRESS <i>Beatrice Johnson 1519 Gilmore St., Baltimore, Md.</i>		18. MEDICAL CERTIFICATION <i>Evisceration cerebrum</i>	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause <i>Amputation L thigh</i> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>(a) Evisceration cerebrum (b) Amputation L thigh (c)</i>		INTERVAL BETWEEN ONSET AND DEATH	
20. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Amputation L thigh</i>		21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. PLACE (Home, farm, factory, street, of office bldg. etc.) <i>Orleans St. #1590 Harvard Ave. Baltimore, Md.</i>	
19a. DATE OF OPERATION <i>2/27/56</i>		19b. MAJOR FINDINGS OF OPERATION <i>Amputation L thigh</i>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>2/27/56 44 m.</i>		PLACE (CITY OR TOWN) (CITY OR TOWN) <i>Harvard Ave. Baltimore, Md.</i>	
INJURY <i>Amputation L thigh</i>		(CITY OR TOWN) (CITY OR TOWN) <i>Harvard Ave. Baltimore, Md.</i>	
INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while work <input type="checkbox"/>		HOW DID INJURY OCCUR? <i>Auto accident</i>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <i>Leroy C Palmer M.D. Deputy Medical Examiner</i>		DATE SIGNED <i>2/27/56</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>3/1/56</i>	
NAME OF CEMETERY OR CREMATORIAL REG. NO. <i>Williamston</i>		LOCATION (City, Town, or County) (State) <i>Williamston, N.C.</i>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <i>Feb 27 1956 G.L. Lewis</i>		24. FUNERAL DIRECTOR ADDRESS <i>Flanagan & Parker, Williamston, NC.</i>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
FEB 29 1934

BUREAU Y. S.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 (OM)

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01813

1843 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	<i>Harford</i> <i>cherdean</i>	MARYLAND LENGTH OF STAY (In this place)	STATE <i>Maryland</i> COUNTY <i>Harford</i> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	<i>Parsius Run. Rural #1.</i>		
3. NAME OF DECEASED (First) <i>Varney</i> (Middle) <i>Arthur</i> (Last) <i>Beall</i>		4. DATE (Month) OF (Day) DEATH Feb. 7th 1943	
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Jan 9th 1882
9. AGE last birthday 74 yrs.	10. KIND OF BUSINESS OR INDUSTRY farmer	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME <i>Samuel H. Beall</i>	14. MOTHER'S M AIDEN NAME <i>Charlotte Wilgis</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Mrs Varney A. Beall - aberdeen	18. MEDICAL CERTIFICATION <i>Cerebral Hemorrhage</i>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<i>Chronic Myocarditis - Hypertension</i>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) Bethel	(County) Harford (State) Maryland
21d. TIME OF INJURY (Month) Feb. (Day) 7 (Year) 1943 (Hour) M.	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4-12 1943 to Feb. 7 1943 , that I last saw the deceased alive on Feb. 6 1943 , and that death occurred at 10 AM M, from the causes and on the date stated above. SIGNATURE <i>John De Grace Jr</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 2/11/56	NAME OF CEMETERY OR Crematory Mt. Zion Cemetery	LOCATION (City, town, or County) Bethel (State) Harford Maryland
24. REC'D BY REGISTRAR Feb. 11-56	REGISTRAR'S SIGNATURE Stellie Q. Perry	25. FUNERAL DIRECTOR'S SIGNATURE John E. Farling aberdeen	
DATE	ADDRESS		

WISCONSIN STATE GOVERNMENT OF HASTINGS-GRANGE

THE GRAPHICS OF DEATH

BUREAU V.

FEB 14 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01814

182

CERTIFICATE OF DEATH

1844

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Harford CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural, Rocks		MARYLAND LENGTH OF STAY (In this place) Hoys		STATE ROCKS CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROCKS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) (Day) (Year) OF DEATH Feb. 24 1956		
Thomas W. Bosley					
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH MARCH 31 1888	9. AGE last birthday 67	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. yrs.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Farming		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas E Bosley			14. MOTHER'S MAIDEN NAME Elizabeth Bosley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		
(If Yes, give war or dates of service)			17. INFORMANT & ADDRESS Elizabeth Bosley Rocks		
18. MEDICAL CERTIFICATION Coronary Thrombosis					
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C) Chr. Cardio-Vascular disease with hypertension					
INTERVAL BETWEEN ONSET AND DEATH 1 hr.?					
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebral thrombosis with hemiplegia					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) Mar. 1954 (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3-19 1954 , to Feb. 24, 1956 , that I last saw the deceased alive on Feb. 22 1956 and that death occurred at M. from the causes and on the date stated above. SIGNATURE Weedard J. Hudson M.D. Forest Hill, Md.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb 24-56		NAME OF CEMETERY OR CREMATORIUM Mt Zion	
24. REC'D BY REGISTRAR 2-28-56		REGISTRAR'S SIGNATURE Russell Foword		LOCATION (City, town, or county) Bellair Md. (State)	
25. FUNERAL DIRECTOR'S SIGNATURE Martin Flury Janiselle Md.					

DEPARTMENT OF STATE - WASHINGTON, D. C.

CERTIFICATE OF DEATH

✓ 28-18-4-1816

11-26-52-1816

✓ V. M. G. 1816

✓ 28-18-4-1817

BUREAU V. S.

MAR 2 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01815

1826

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 HAURE de GRACE	c. LENGTH OF STAY IN 1b 1 1/2 HRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE de GRACE 24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21 HARFORD MEMORIAL Hosp.	d. STREET ADDRESS 519 N. Adams		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Michael Gorman Boyd	First	Middle	Last
4. DATE OF DEATH FEBRUARY 22, 1956	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/25/07
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD		10b. KIND OF BUSINESS OR INDUSTRY Pan Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael P. Boyd		14. MOTHER'S MAIDEN NAME MARGARET Connors	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W.W.I		16. SOCIAL SECURITY NO. Munson	
17. INFORMANT John Boyd, 519 N. Adams Harford		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Arthur Schuster Carbo Vasculas INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Hypertension Disease			
(c) DUE TO Coronary Thrombosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/10, 1922 to 2/22, 1922, that I last saw the deceased alive on 2/22, 1922, and that death occurred at 10 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Charles J. Foley M.D. Harford Dean Feb 23/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/56	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet		22d. LOCATION (City, town, or county) (State) Harford Dean Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lummington Rm. Harford Dean, Md.		24a. REC'D BY REGISTRAR DATE 1/25/56	
PHYSICIAN'S NAME (Type)		24b. REGISTRAR'S SIGNATURE G. L. Lewis, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF JUSTICE - BUREAU OF INVESTIGATION
CERTIFICATE OF DEATH

BUREAU U. S.

FEB 28 195

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

01816

CERTIFICATE OF DEATH
1845 FOR MEDICAL EXAMINERS

Reg. Dist. No. 18

1. PLACE OF DEATH COUNTY <i>Harford</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hawrede Grace</i>		LENGTH OF STAY (In this place) <i>area</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rural #1 - Robin Hood Road</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hawrede Grace Rural</i>	
STREET ADDRESS <i>Robin Hood Road Area</i>		COUNTY <i>Harford</i>	
3. NAME OF DECEASED (Type or Print) <i>Walter Charles Burkertine</i>		4. DATE (Month) OF DEATH <i>February 20</i>	
5. SEX <i>Male</i>		(Year) <i>1956</i>	
6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Widower</i>	
8. DATE OF BIRTH <i>June 28-1879</i>		9. AGE last birthday 76. yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer self emp</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Thomas Burkertine</i>		14. MOTHER'S MAIDEN NAME <i>Mary Herwane</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-07-3168</i>	
17. INFORMANT AND ADDRESS <i>Ted Burkertine #2 6th Street Aberdeen MD</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <i>Arteriosclerotic CV disease</i> Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <i>Lerold E Palmer M.D.</i> (Degree or title) <i>Deputy Medical Examiner Harford County</i> DATE SIGNED <i>2/20/56</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Feb 22-1956</i>	
DATE REC'D BY LOCAL REG. REC.		NAME OF CEMETERY OR CREMATORIAL <i>Avalon South Cemetery</i>	
REG. REC.		LOCATION (City, town or county) (State) <i>Yetta, York Co Pennsylvania</i>	
REG. REC.		24. FUNERAL DIRECTOR ADDRESS <i>John F. Barringer Aberdeen MD</i>	
REG. REC.		REG. REC.	

BURLAU V. 1

FEB 27 1962

LIBRARY
UNIVERSITY OF TORONTO LIBRARIES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1827

CERTIFICATE OF DEATH

01817 -

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Hartford</i>		MARYLAND <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY <i>Hartford</i>	
<i>Havre de Grace</i>	56	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
<i>Hartford Memorial Hospital</i>	146 Bloomsbury Ave		
3. NAME OF DECEASED (Type or print)	First <i>Victor</i>	Middle <i>George</i>	Last <i>Cookley</i>
4. DATE OF DEATH	Month <i>FEB.</i>	Day <i>27</i>	Year <i>1956</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Male</i>	<i>White</i>	<i>WIDOWED</i> <input type="checkbox"/>	<i>6/6/1899</i>
9. AGE (In years from birthdate) <i>56</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Plumber U.S. Chemical</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Eugene Cookley</i>	14. MOTHER'S MAIDEN NAME <i>Myrtle Gilbert</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Willie S. Cookley Havre de Grace Md</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</i> DUE TO <i>Acute myocarditis</i>			
INTERVAL BETWEEN ONSET AND DEATH: <i>2 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
20g. ADDRESS (Street, city or town, state)	DATE SIGNED		
21. I certify that I attended the deceased from <i>Feb. 26, 1956</i> to <i>Feb. 27, 1956</i> , that I last saw the deceased alive on <i>Feb. 27, 1956</i> , and that death occurred at <i>429 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles J. Flanagan</i>	M.D.	<i>Havre de Grace Md</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>MAR. 1, 1956</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>ANGEL HILL CEM.</i>	22d. LOCATION (City, town, or county) (State) <i>HAYRE DE GRACE, MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Madison Mitchell, Havre de Grace Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>Feb. 29, 1956</i>	24b. REGISTRAR'S SIGNATURE <i>G. L. Lewis M.D.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

27

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REGGIE LEE

MARYLAND STATE DEPARTMENT OF HEALTH

01818

CERTIFICATE OF DEATH

1846

FOR MEDICAL EXAMINERS

Reg. Dist. No. 155

1. PLACE OF DEATH COUNTY <u>Harford</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Randall House of Grace</u> <u>Oakington</u>		TOWN <u>Harford Grace</u>	
LENGTH OF STAY (to this place) <u>10 yrs</u>		STREET (If rural, give location) <u>Connerton St.</u>	
3. NAME OF DECEASED (First) (Type or Print) <u>George Amos Curry</u>		4. DATE OF DEATH <u>February 16</u> (Month) (Day) (Year) <u>1956</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>JUNES 1883</u> 9. AGE last birthday <u>72</u> yr. <u>11</u> under 1 year Months <u>0</u> Days <u>0</u> under 24 hrs. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Curry</u>		14. MOTHER'S MAIDEN NAME <u>Susan Motterey</u>	
15. WAS DECLARED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Sarah Jane Curry, Randall House</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>441</u> Immediate cause <u>Artherosclerotic CV disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last <u>—</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or office bldg., etc.) <u>—</u>	
(CITY OR TOWN) <u>—</u>		(COUNTY) <u>—</u>	
(STATE) <u>—</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <u>—</u>		DATE SIGNED <u>2/16/56</u>	
SIGNATURE <u>Gerald E Palmer MD</u>		ADDRESS <u>Deputy Medical Examiner Baltim. Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2-18-1956</u>	
NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <u>Herming Ch. Yard Harford Co.</u>		(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 17 1956</u>		REG. <u>C. L. Lewis M.A. P. Madison Michel, Randall House, Md.</u>	
REG. <u>Feb 17 1956</u>		REG. <u>C. L. Lewis M.A. P. Madison Michel, Randall House, Md.</u>	
REG. <u>Feb 17 1956</u>		REG. <u>C. L. Lewis M.A. P. Madison Michel, Randall House, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the names of health cleanly and legibly.

UNITED V. S.

FEB

1951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1828

CERTIFICATE OF DEATH

018195-

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE Maryland b. COUNTY CECIL	
Harde Grace		8 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		d. STREET ADDRESS	
Harford Memorial Hospital		Arch St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Henry		W.		Davis	February 24 1956
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Male		White		B. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Fisherwoman		Retired		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Edward K. Davis		Cecilia Kelly		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Lizzie Davis (wife) Perryville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Chronic Myocarditis			
442.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		INTERVAL BETWEEN ONSET AND DEATH 10 days			
{ (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Cerebral Sclerosis - Arterio Sclerosis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1, 1955 to Feb. 27, 1956 that I last saw the deceased alive on Feb. 24, 1956, and that death occurred at 816 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, State)		DATE SIGNED Port Ricait 2/25/56	
ACTUAL SIGNATURE <i>C. I. BENSON</i>		M.D.			
PHYSICIAN'S NAME (Type) C. I. BENSON					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-1956		22c. NAME OF CEMETERY OR CREMATORIAL North East	
22d. LOCATION (City, town, or county) North East, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Lee Patterson & Son Perryville, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE Feb. 25, 1956	
				24b. REGISTRAR'S SIGNATURE L. D. Lewis Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: At time this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

July 28

18

18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01820

1847 CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY Harford		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		c. LENGTH OF STAY IN 1b 50 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Harford	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR INSTITUTION				d. STREET ADDRESS /				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rebecca		First Rebecca		Middle 		Last Dorsey		4. DATE OF DEATH Feb. 19 1956	
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1875		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Servant		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Abraham Dorsey				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Edith Harris		Address Abingdon, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO							
{		DUE TO		{		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive Cardiovascular disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12/23 1955 to 2/19 1956 , that I last saw the deceased alive on 2/16 1956 , and that death occurred at M , from the causes and on the date stated above. ACTUAL SIGNATURE George T. Stansbury PHYSICIAN'S NAME (Type) George T. Stansbury						ADDRESS (Street, city or town, state) 569 Revolution St., Havre de Grace Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 22, 1956		22c. NAME OF CEMETERY OR CREMATORIUM John Wesley		22d. LOCATION (City, town, or county) Abingdon, Harford, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son, Abingdon, Md.		ADDRESS		24a. REC'D BY REGISTRAR Feb. 22, 1956		24b. REGISTRAR'S SIGNATURE Norma Moore			

HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be completed within 24 hours after death. Log in
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached or use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01821

1848 CERTIFICATE OF DEATH

Reg. Dist. No. 182

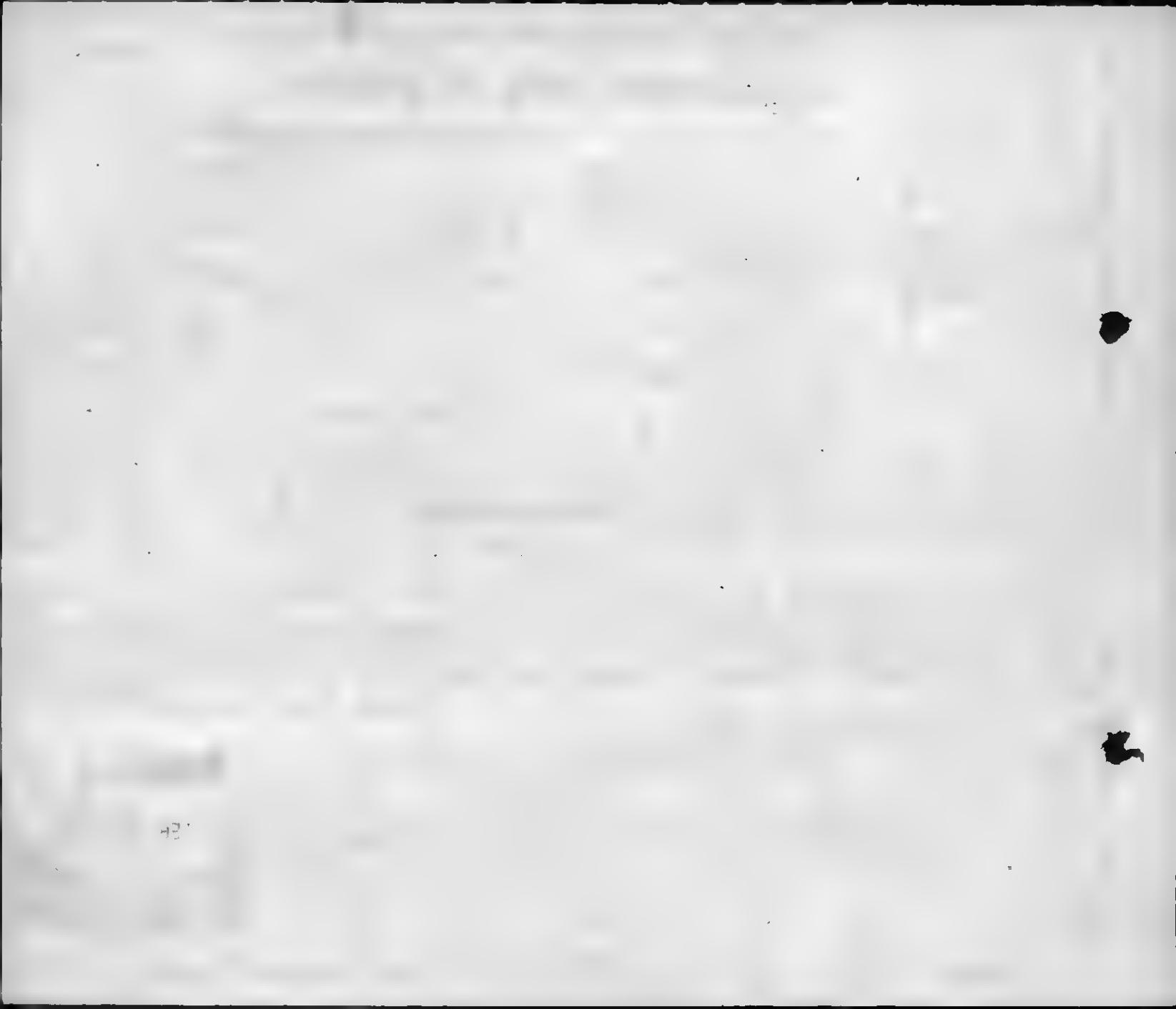
INSTRUCTIONS

TO ATTENDING PHYSICIAN HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a transit permit.

VS 155-10

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Maryland Jarrettsville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	70 yrs	STREET ADDRESS	(If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) OF DEATH	
Alice Gertrude Eggleson		Feb 6 th 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	White	Single	Dec 13 1877 78
9. AGE last birthday IF UNDER 1 YEAR yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher (Retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Hess, Harford, Md		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Joseph E. Eggleson		Emma Frances Blaney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
Miss Estelle Eggleson		Malnutrition 6 months	
Diseases or conditions directly leading to death		Antecedent cause(s) due to Diseases or conditions, if any, giving rise to the above cause stating underlying cause last. Due to	
IMMEDIATE CAUSE (A) Malnutrition		B) Lack of appetite & Anemia 1 year	
C) Cervicaloma of Small Bowel 1 year			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		None	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 19, 1956, to June 30, 1956, that I last saw the deceased alive on June 30, 1956, and that death occurred at 5:30 P.M. from the causes and on the date stated above. SIGNATURE: <i>W. James Horning</i> M.D. ADDRESS (Street, city, town, state) Jarrettsville, Md. DATE SIGNED 2/7/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		Feb 6-56 Jarrettsville	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	
DATE 2-10-56		Priscilla Lawwood	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Maurice Kirtz Jarrettsville		Md.	



1849 CERTIFICATE OF DEATH

Reg. Dist. No. 182

INSTRUCTIONS
TO ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Harford CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN JARRETTSVILLE (Rural) HOSPITAL OR INSTITUTION OR STREET ADDRESS		STATE Maryland COUNTY HARFORD - CITY (If outside corporate limits, write RURAL and give nearest town) TOWN (Rural) JARRETTSVILLE STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) George Edward Emrick		4. DATE OF DEATH Feb 3rd 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Retired	8. DATE OF BIRTH Feb 2 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Jarrettsville Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Emrick		14. MOTHER'S MAIDEN NAME Catharine Hess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT & ADDRESS Charles H. Goleman Rockford		18. MEDICAL CERTIFICATION ARTERIOSCLEROTIC HEART DISEASE Generalized ARTERIOSCLEROSIS	
19a. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CHRONIC BRONCHIECTASIS		INTERVAL BETWEEN ONSET AND DEATH 25 yrs	
19b. DATE OF OPERATION		19c. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) —	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M. —		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 20 June 1955 , to 3 FEB 1956 , that I last saw the deceased alive on 1 Feb 1956 , and that death occurred at 5:30 AM , from the causes and on the date stated above.			
SIGNATURE Thomas A. Mosley Jr. M.D. ADDRESS (Street, city, town, state) 3 FEB 1956 DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb 5-56 NAME OF CEMETERY OR CREMATORIUM Salem Jarrettsville Harford Md LOCATION (City, town, county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Priscilla Finwood 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
DATE 2-7-56		—	

EEB

01823
Reg. Dist.

1850

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 7

1. PLACE OF DEATH:

COUNTY Harford MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN Sparrows Point, Baltimore

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Shoe Factory

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY

CITY (If outside corporate limits write RURAL and give nearest town)
TOWN Sparrows Point, Baltimore

(If rural, give location)

STREET ADDRESS 1219 Beechwood Road

3. NAME OF DECEASED:
(Type or Print)

(First) MELVIN (Middle) JACKSON (Last) ESTES

4. DATE (Month) (Day) (Year)
OF DEATH 2 4 1955

5. SEX:

6. COLOR OR RACE:
White7. SINGLE, MARRIED,
WIDOWED, DIVORCED,

(Specify):

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service) Yes 11-16-55 to present

16. SOCIAL SECURITY NO.: 17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) DUE TO

Antecedent cause(s) (b) DUE TO

Diseases or conditions, if any, giving rise to the above cause DUE TO

stating underlying cause last (c)

2. INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes No 21a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 2 4 56 2230M.

21e. INJURY OCCURRED While at Not while

work at work

21f. HOW DID INJURY OCCUR? Automobile Accident

22. I hereby certify that I took charge of the remains described above; held an Autopsy , Inspection , Inquiry , andfind that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

DATE SIGNED 8-5-56

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF 2-1-56

NAME OF CEMETERY OR CREMATORIAL Rio Church Cem.

LOCATION (City, town, or county) (State)

Clarksville, Indiana

DATE REC'D BY LOCAL REG.

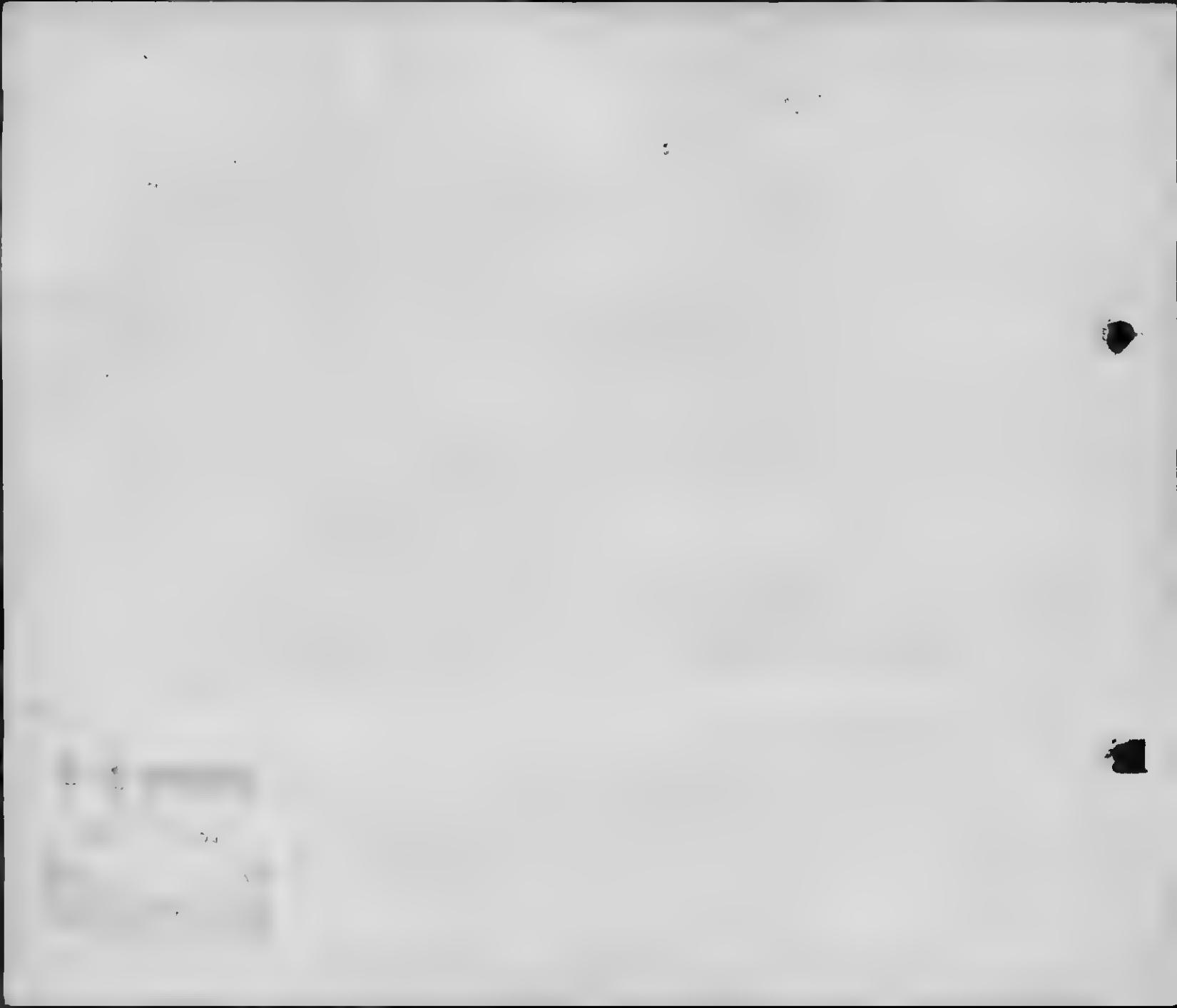
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Kenny S. Brantley

Kenny S. Brantley, Esq., Allegheny, Pa.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01824

1829 CERTIFICATE OF DEATH

Reg. Dist. No. 18

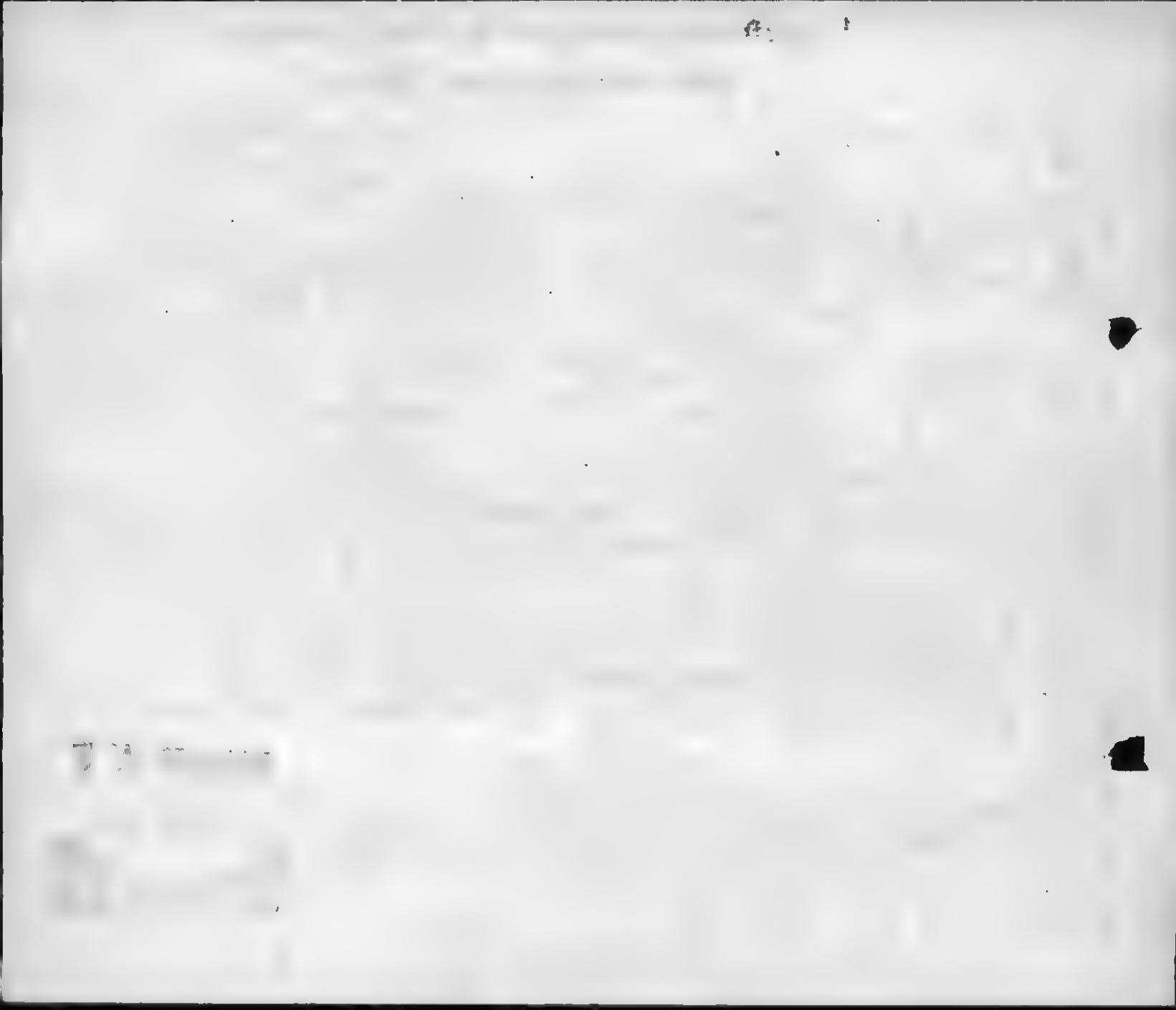
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ATSC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN)	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Maryland aberdeen
HOSPITAL OR INSTITUTION # STREET ADDRESS	#401 Wyandot Ave.	STREET ADDRESS	#401 Wyandot Ave.
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First)	(Middle)	(Last)	Feb 17 1902
Male	white	Single, MARRIED, WIDOWED, DIVORCED, (Specify)	DATE OF BIRTH
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday
Salesman retired		Executive Industries	77 yrs.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Albert Fassnacht		Hattie Lasher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
No		223-01-7287	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
Mrs. Miller & Fassnacht, Aberdeen, Md.		Cirrhosis of liver, Carditis, bronchitis Knee sprain Death of myocarditis.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT, WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/10, 1902</u> to <u>2/17, 1902</u> , that I last saw the deceased alive on <u>2/17, 1902</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above. ATTACHED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM
Removal		Feb 18-1902	East Akron Cemetery
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	LOCATION (City, town, or county) (State)
		Nellie Q. Perry	Akron, Ohio.
DATE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
Feb 18-56		John G. Tarrig, Aberdeen, Md.	



01825

Reg. Dist.

1830

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 181

1. PLACE OF DEATH:

COUNTY

Harford

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN Aberdeen

LENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

6 Post Road.

3. NAME OF
DECEASED:
(Type or Print)

(First) Oliver

(Middle) D

(Last) Frock

4. DATE
OF
DEATH February 9 1956

5. SEX:

Male

6. COLOR OR
RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): single8. DATE OF BIRTH:
June 17-18959. AGE last birthday:
60 yrs.IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired)10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

West Virginia

12. CITIZEN OF WHAT
COUNTRY: USA

13. FATHER'S NAME:

John Thomas Frock

14. MOTHER'S MAIDEN NAME:

Elizabeth Barker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or blank.) (If Yes, give war or dates of
service)

Yes

16. SOCIAL SECURITY NO.: 220-22-0348

17. INFORMANT & ADDRESS:
Richard E. Frock 404 W. Wash St.

Berkeley Springs W. Va.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a)
DUE TOAntecedent cause(s)
Diseases or conditions, if any, (b)
giving rise to the above cause DUE TO

stating underlying cause last (c)

2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

3. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?
Yes No 21a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
of street, office bldg., etc.,
INJURY)21c. (City or town) (County)
(State)21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY M.21e. INJURY OCCURRED
While at Not while
work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , andfind that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE Edward C. Palmer

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

DATE SIGNED 2/9/56

23. BURIAL, CREMATION,
REMOVAL (Specify): Removal

DATE REC'D BY LOCAL REG. REC.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: This law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1851

CERTIFICATE OF DEATH

01826

Reg. Dist. No. 181

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	MARYLAND LENGTH OF STAY (In this place) 10 yrs	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY HARFORD PERRYMAN (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS		
3. NAME OF DECEASED (Type or Print)	(First) MARY	(Middle) ELLEN	(Last) GILBERT
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH DEC. 10, 1888
9. AGE last birthday 67 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Richard Hannay		
14. MOTHER'S MAIDEN NAME Catherine V. Holloway	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		
16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Oakley B. Gilbert, Perryman MD.		
B. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE Antecedent cause(s) DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last.	18. MEDICAL CERTIFICATION Cirrhotic megacardial degeneration Diabetes mellitus		
INTERVAL BETWEEN ONSET AND DEATH			
C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21c. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb. 17, 1956</u>, to <u>Feb. 18, 1956</u>, that I last saw the deceased alive on <u>Feb. 17, 1956</u>, and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <i>Edward J. Holloway</i>	ADDRESS (Street, city, town, state) <i>Perryman, Md.</i>	DATE SIGNED <u>1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF 2-21-1956	NAME OF CEMETERY OR CREMATORIUM BAKER'S CEM.	LOCATION (City, town, or county) HARFORD
24. REC'D BY REGISTRAR DATE Feb. 20-56	REGISTRAR'S SIGNATURE Nellie J. Perry	25. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell, HAVRE DE GRACE	ADDRESS Mo.

8 100

FED

WELC

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01827

1831 CERTIFICATE OF DEATH

Reg. Dist. No. 185

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 FORM

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Harford (If rural, give location)		
Havre de Grace	3 DAYS	Harford Havre de Grace	3185 Union Street		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Harford Memorial Hospital				
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH			
FIRST: IRA	MIDDLE: Herman	LAST: Hall	Month: February Day: 16 Year: 1956		
5. SEX Male	6. COLOR OR RACE: White	7. SINGLED, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: 5/7/1905	9. AGE last birthday 50 yrs.	IF UNDER 1 YEAR Months: 0 Days: 0 Hours: 0 Min: 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY: CIVILIAN GUNNER	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Robert G Hall		14. MOTHER'S MAIDEN NAME: Laura B		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	
				16. SOCIAL SECURITY NO. 214-18-6440	
17. INFORMANT & ADDRESS: Mrs. VICTORIA HALL HAVRE DE GRACE		18. MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH 3 days	
IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(A) DUE TO Central Hemorrhage		(B) DUE TO Hypertension Cardiovascular Disease	
IT OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
20a. DATE OF OPERATION		20b. MAJOR FINDINGS OF OPERATION		20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1953, to Feb 16, 1956, that I last saw the deceased alive on Feb 16, 1956, and that death occurred at 9:20 P.M., from the causes and on the date stated above. SIGNATURE: <i>Hereward J. Stetson</i> M.D. ADDRESS: <i>1711 Hill Blvd. Aberdeen Md. 21001</i> DATE SIGNED: <i>2/17/56</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) I.C.P.H.L.		DATE THEREOF 2/19/1956	NAME OF CEMETERY OR CREMATORIAL DARLINGTON CEM.	LOCATION (City, town, or county) HARFORD Co. MD.	
24. REC'D BY REGISTRAR DATE 2/17/1956		REGISTRAR'S SIGNATURE A. F. Lewis M.D.		25. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell HAVRE DE GRACE MD.	



FEB

01828

1832

**CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS**

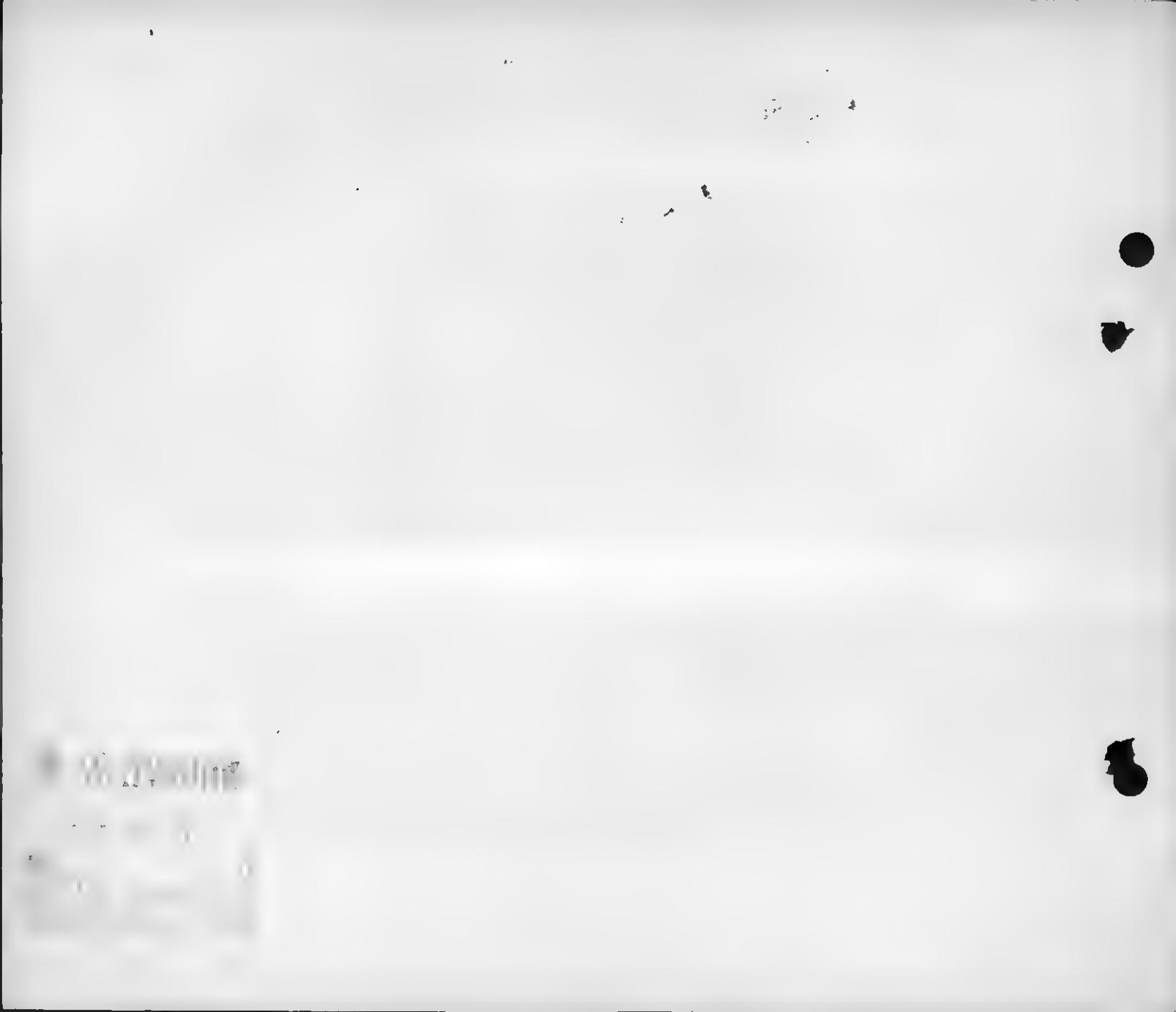
Reg. Dist. No.... 13

181

I. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
<i>Harford</i> MARYLAND		<i>Alabama</i> COUNTY <i>Jefferson</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		TOWN	<i>Birmingham</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS	<i>90 Flying Clipper trailer Court.</i>		
STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Pierce</i>	(Middle) <i>Morgan</i>	4. DATE OF DEATH <i>February 11</i> (Year) <i>1956</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>	8. DATE OF BIRTH <i>Oct 25-1911</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sheet metal worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sheet metal</i>	9. AGE last birthday <i>44</i> yrs. II under 1 year Months Days Hours Min.
13. FATHER'S NAME <i>Robert H. Hendry</i>		11. BIRTHPLACE (State or foreign country) <i>Alabama</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY No. <i>War II</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
17. INFORMANT AND ADDRESS <i>Robert's Valley Chapel Funeral Home</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause <i>A suffocation due to fire</i> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (a) _____ (b) _____ (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY! Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	(CITY OR TOWN) <i>Aberdeen</i> (COUNTY) <i>Harford</i> (STATE) <i>MD</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>2/11/56</i> <i>8 AM</i>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <i>His trailer caught fire</i>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <i>Levold C Palmer</i> (Degree or title) <i>ND</i> ADDRESS <i>Deputy Medical Examiner</i> DATE SIGNED <i>2/11/56</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Removal</i>	DATE THEREOF <i>Feb 12-1956</i>	NAME OF CEMETERY OR CREMATORIAL <i>Birmingham</i>	LOCATION (City, town, or county) <i>Alabama</i> (State)
DATE REC'D BY LOCAL REG. <i>Feb. 11-1956</i>	REGISTRAR'S SIGNATURE <i>Nellie G. Perry</i>	24. FUNERAL DIRECTOR ADDRESS <i>John E. Sappington Aberdeen, MD</i>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01831

1852

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY HARFORD MARYLAND

CITY (If outside corporate limits, write RURAL and LENGTH OF STAY
OR give nearest town) RURAL (in this place)TOWN ABERDEEN
HOSPITAL OR
INSTITUTION OR
STREET ADDRESS3. NAME OF
DECESSED
(Type or Print)

(First) FELIX (Middle) A.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY HARFORD CO.CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWNSTREET ADDRESS Route 40 R.D. #1 Aberdeen Md.
(If rural, give location)

4. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED
(Specify)

Widowed

(Last) McNALLY

4. DATE
OF
DEATH

1876

(Month) FEB (Day) 10 (Year) 1956

8. DATE OF BIRTH

1876

9. AGE last birthday 80 yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

Postalman Telephone Co

11. BIRTHPLACE (State or foreign country)

Aldi More, Md.

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

Felix A. McNally

14. MOTHER'S MAIDEN NAME

Alice McGovern

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or Unknown)

(If yes, give war or dates of
service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS

Mrs. C. M. Walker-Route 40 R.D. 1

Aberdeen, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

44-1 Immediate cause

(a) Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(b)

(c)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(d)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(e)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(f)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(g)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(h)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(i)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(j)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(k)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(l)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(m)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(n)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(o)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(p)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(q)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(r)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(s)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(t)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(u)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(v)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(w)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(x)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(y)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(z)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(aa)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(bb)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(cc)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(dd)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(ee)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(ff)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(gg)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(hh)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(ii)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(jj)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(kk)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(ll)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(mm)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(nn)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(oo)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(pp)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(qq)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(rr)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(ss)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(tt)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(uu)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(vv)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(ww)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(xx)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(yy)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(zz)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(aa)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(bb)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(cc)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(dd)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(ee)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(ff)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(gg)

Antecedent cause(s)

Disease or conditions, if any,

giving rise to the above cause

7

INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5510M

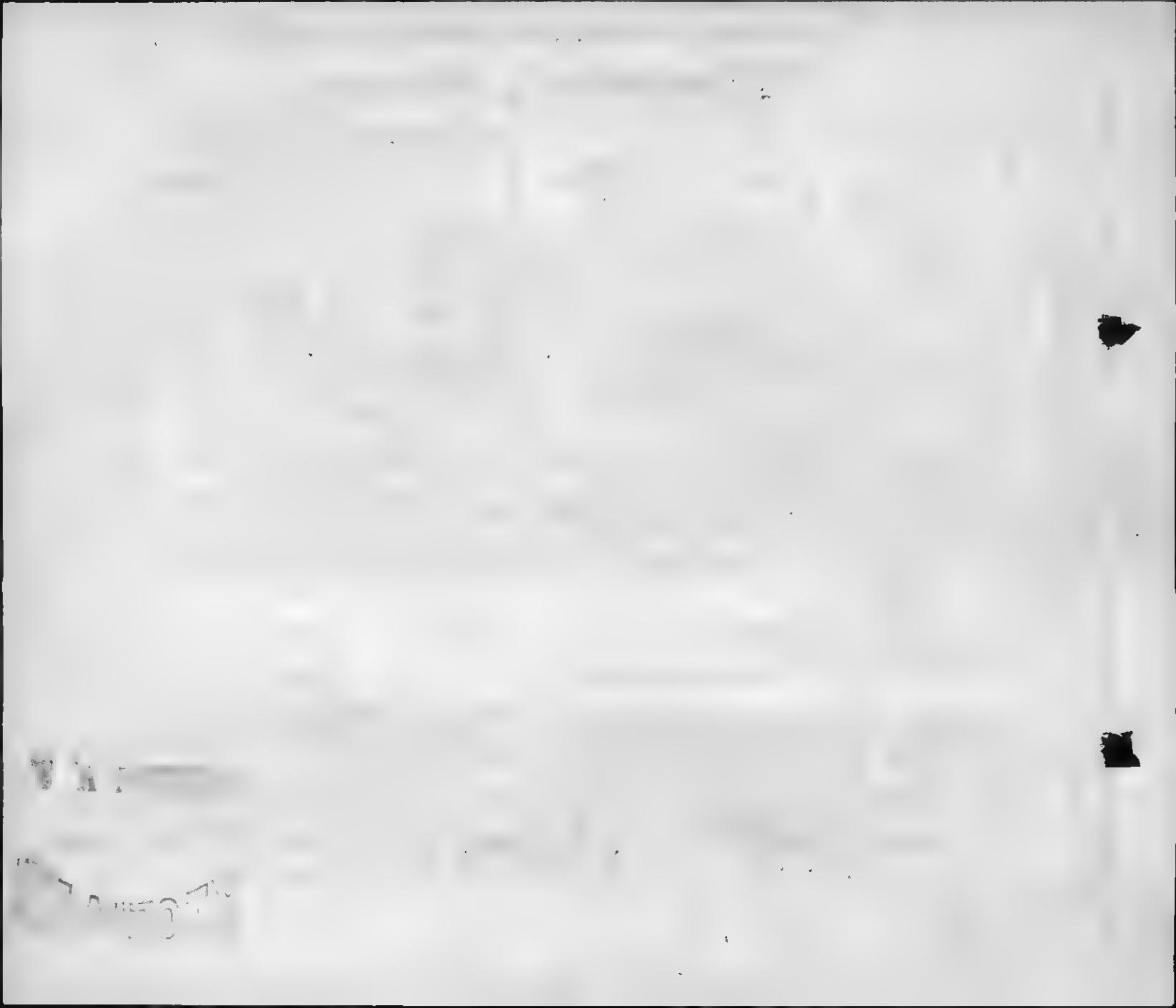
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1853 CERTIFICATE OF DEATH

01832

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE Tennessee CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Athens		COUNTY (If rural give location)	
X Tennessee				STREET ADDRESS			
HOSPITAL OR INSTITUTION OR STREET ADDRESS JS Army Hospital Aberdeen Proving Ground							
3. NAME OF DECEASED (First) JAMES (Middle) BABY Ray (Last) MURPHY				4. DATE OF DEATH February 18 1956			
5. SEX Male	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH 13 Apr 23	9. AGE last birthday 32 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier				10b. KIND OF BUSINESS OR INDUSTRY US Army			
11. BIRTHPLACE (State or foreign country) Tennessee				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Deceased (Ink own)				14. MOTHER'S MAIDEN NAME Deceased (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes ✓ (If Yes, give war or dates of service) 1974				16. SOCIAL SECURITY NO. 410-20-7653			
17. INFORMANT & ADDRESS Official US Army Records, (phone) ACC, Md				18. MEDICAL CERTIFICATION Subarachnoid hemorrhage, exs. size Fracture 3-4-5-6 ribs and 2nd costal cartilage on right. Fracture, scille, 13. mm Laceration, cont lacer w. t. hemorrhage.			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				20. INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION None (DOA)		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of, injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Route #40, between Aberdeen and Georgeod.		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12 2000 Feb 18 56		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Vehicle accident		d	
22. I hereby certify that I attended the deceased from DOA, 19, to 19, that I last saw the deceased alive on 19, and that death occurred at .M, from the causes and on the date stated above. <i>J. R. Stevens Capt Reg M.D.</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb 20th 1956		NAME OF CEMETERY OR CREMATORIUM Ground		LOCATION (City, town, county) Athens Tennessee	
24. REC'D BY REGISTRAR DATE Feb. 20-1956		REGISTRAR'S SIGNATURE J. R. Stevens		25. FUNERAL DIRECTOR'S SIGNATURE John G. Tarrington		ADDRESS Aberdeen Md.	



INSTRUCTIONS

TO ATTENDING PHYSICIAN IN HOSPITAL: This law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 153.10.W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01833

1854 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN)		MARYLAND LENGTH OF STAY (in this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY Maryland Bel Air (If rural give location)	
Harford Rural Bel Air		3 years		Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)		[First] Martha	(Middle)	[Last] NELSON		4. DATE OF DEATH	
5. SEX Female	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 2/28/1914	9. AGE last birthday 80 yrs.	(Month) February 10		(Day) 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JIN KNOLL		14. MOTHER'S MAIDEN NAME Annie Connes		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS Clarence Johnson	
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral hemorrhage							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Chr. cardio-vascular disease							
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from January 20 1956, to February 10 1956, that I last saw the deceased alive on Feb. 7, 1956, and that death occurred at 6:45 A.M. from the causes and on the date stated above. SIGNATURE Willard P. Anderson M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF Feb 13/56	NAME OF CEMETERY OR CREMATORIUM Tobacco Neck		LOCATION (City, town, or county) Forest Hill, Md.		DATE SIGNED February 10, 1956
24. REC'D BY REGISTRAR DATE 2-11-56		REGISTRAR'S SIGNATURE Priscilla Lowood	25. FUNERAL DIRECTOR'S SIGNATURE Joe 1956 / T. J. T. A. C. G. C. M.		ADDRESS		

87 100

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01834

1833 CERTIFICATE OF DEATH

Reg. Dist. No.

187

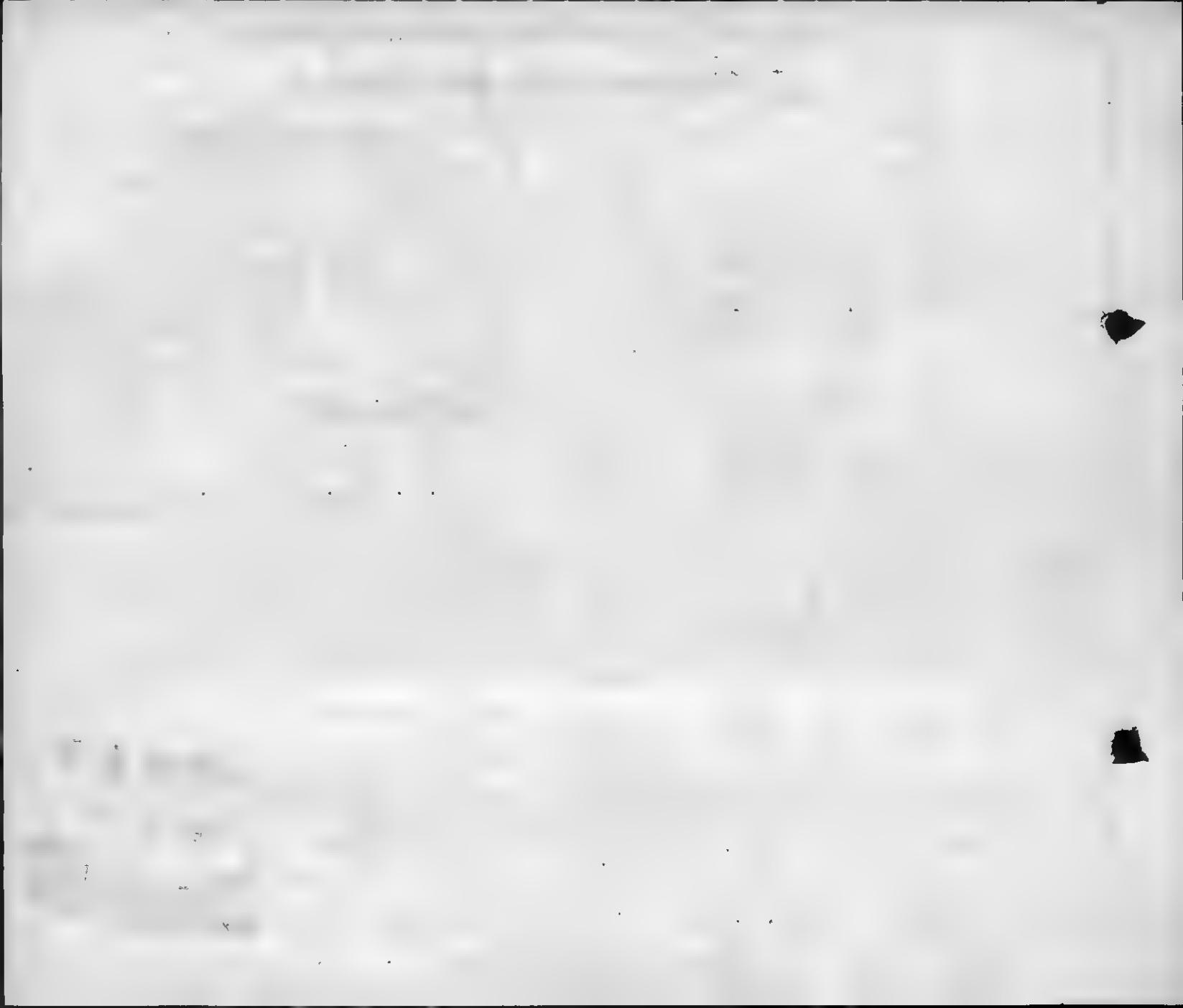
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND Bel Air	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Maryland Bel Air
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Grafton Shop Road	STREET ADDRESS	Grafton Shop Road
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
Mrs. Catherine		Price	February 2nd 1956
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 20 Jan 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 73 yrs.
13. FATHER'S NAME Charles Dieter		14. MOTHER'S MAIDEN NAME Mary Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Md. Mrs. M. Eliz. Treadwell, Box 266 Bel Air
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) DUE TO (C)	Cardio-respiratory failure Central embolus Congestive heart failure	35 hours 35 hours 1 year
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic cardiovascular dis.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 19.49, to 19.50, that I last saw the deceased alive on 1.1.56, and that death occurred at 11:15 P.M., from the causes and on the date stated above. SIGNATURE: <i>J. J. Dieter</i> M.D. 138 N. Main Bel Air, Md. 3 Feb 56 DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 6, 1956	NAME OF CEMETERY OR CREMATORIUM Holy Redeemer Cemetery
24. REC'D BY REGISTRAR DATE Feb. 7, 1956		REGISTRAR'S SIGNATURE <i>Priscilla Forward</i>	LOCATION (City, town, or county) Baltimore, Maryland
25. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1834

CERTIFICATE OF DEATH

01835
183-

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
		a. STATE Maryland		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hosp.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Arthur Ragan		First	Middle	Last	4. DATE OF DEATH February 29 1956
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb 12 1893	9. AGE (In years legal birthday) 63 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanice		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Conowingo, Cecil Co Md USA	
13. FATHER'S NAME John W. Ragan		14. MOTHER'S MAIDEN NAME Hannah Green		12. CITIZEN OF WHAT COUNTRY? Citizenship	
15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 814-34-3331		17. INFORMANT Wm John Ragan, Conowingo, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis and hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and arteriosclerotic cardiovascular disease DUE TO Cataract disease (c)				INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypostatic Congestion of lungs.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20e. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 211 N Union Ave, Harford Space, Md.	
20f. (City or town) Harford		(County) Harford		(State) Md.	
21. I certify that I attended the deceased from Feb 11th 1956 to Feb 29th 1956 that I last saw the deceased alive on Feb 29th 1956 and that death occurred at 125 PM from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) 211 N Union Ave, Harford Space, Md.					
DATE SIGNED Feb 29th 1956					
ACTUAL SIGNATURE Edward C. Lee, M.D.					
PHYSICIAN'S NAME (Type) Edward C. Lee, M.D.		22c. NAME OF CEMETERY OR CREMATORIUM Pleasant Grove		22d. LOCATION (City, town, or county) Peach Bottom Pa.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Mary 4, 1956		22b. DATE THEREOF Mar 4, 1956		(State) Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Syms, Rising Sun Md.		ADDRESS 15A 15 (4) 15M 9/55		24a. REC'D BY REGISTRAR DATE Mar 4-56	
				24b. REGISTRAR'S SIGNATURE G. L. Lewis M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BENEDY V. S.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0183G

1835 CERTIFICATE OF DEATH

Reg. Dist. No. 1835

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY HARFORD		MARYLAND		STATE MD		COUNTY HARFORD	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS	
TOWN HARVE DE GRACE		LIFE		HAVRE DE GRACE		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
NORMAN WIDMER REYNOLDS				(Month) Sep.	(Day) 11	(Year) 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH SEPT. 17, 1890	9. AGE last birthday 65	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN				10b. KIND OF BUSINESS OR INDUSTRY CANNING HOUSE			
11. BIRTHPLACE (State or foreign country) MD				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME THOMAS PEYNOLDS				14. MOTHER'S MAIDEN NAME CATHERINE SCHUTT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? YES WORLD WAR #1				16. SOCIAL SECURITY NO. 215-12-1568			
17. INFORMANT & ADDRESS W. REYNOLDS, PERRYVILLE, MD				18. MEDICAL CERTIFICATION Coronary occlusion			
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Coronary occlusion ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
20. INTERVAL BETWEEN ONSET AND DEATH							
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at 4:45 P.M., from the causes and on the date stated above. <i>Leroy C Palmer</i> M.D. Deputy Medical Examiner 2/12/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2-14-1956		NAME OF CEMETERY OR CEMATORIUM ANGEL HILL CEM		ADDRESS (Street, city, town, state) LOCATION (City, town, or county) HAVRE DE GRACE, MD	
24. REC'D BY REGISTRAR DATE Feb. 14-1956		REGISTRAR'S SIGNATURE C. L. Lewis		25. FUNERAL DIRECTOR'S SIGNATURE R. Madison H. Miller		ADDRESS HAVRE DE GRACE, MD	

FEB 15 1950

BUREAU V. S.

RECEIVED

01837

1836 CERTIFICATE OF DEATH

Reg. Dist. No. 182

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 15-10A

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Bel Air</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u>		MARYLAND LENGTH OF STAY (in this place) <u>30 years</u> STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Lucy Alvarado</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 27 1956</u>	
S. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Widowed	<u>Sept 18 1877 708</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Housewife</u>		<u>None</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>U.S.A.</u>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Jed J. Stewart</u>		<u>Clarkson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		<u>14-14-5271</u>	
17. INFORMANT & ADDRESS		<u>Dr. B. F. Smith, M.D.</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		<u>Cerebral Hemorrhage</u> <u>Chronic Hypertensive Cardio-vascular Disease</u> <u>'20 minutes</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Thrombosis (May, 1955 & Nov., 1955)</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 19.40..... to Feb. 27..... 19.56....., that I last saw the deceased alive on Feb. 25..... 19.56....., and that death occurred at 7:20 A.M. from the causes and on the date stated above.			
SIGNATURE <u>Willard P. Hudson</u> M.D. ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>			
23. BURIAL, CREMATION, REMOVAL-(SPECIFY)		DATE THEREOF <u>March 1, 1956</u> NAME OF CEMETERY OR CREMATORIUM <u>Forest Hill Cemetery</u> LOCATION (City, town, or county) <u>Forest Hill, Md.</u> (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. S. Bailey</u> ADDRESS	
DATE <u>Mar. 1, 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Bailey</u> ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1855 CERTIFICATE OF DEATH

01838
18d

Reg. Dist. No. 18d

I. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>HARFORD</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>HARFORD</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>BELAIR RD</i>	LENGTH OF STAY (in this place) <i>.51 years</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>BELAIR RD</i>	(If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Walters Nursing Home</i>	STREET ADDRESS		
3. NAME OF DECEASED (First) <i>CORA</i> (Middle) <i>E</i> (Last) <i>Ralson</i> (Type or Print)	4. DATE OF DEATH <i>Feby 4</i> (Month) <i>1956</i> (Year)		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>July 10 - 1871</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>House duties</i>	11. BIRTHPLACE (State or foreign country) <i>Catonsville Md</i>
13. FATHER'S NAME <i>Richard Ralson</i>		14. MOTHER'S MAIDEN NAME <i>Frances Cash</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or blank.)		16. SOCIAL SECURITY NO. <i>C</i>	
17. INFORMANT & ADDRESS <i>Albert Stralson Belair Rd</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Cerebral vascular accident</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic cardiovascular disease</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> N. at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov. 16, 1955</i> , to <i>Feb. 4, 1956</i> , that I last saw the deceased alive on <i>Feb. 4, 1956</i> , and that death occurred at <i>7:45 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Robert Brinkley M.D.</i> ADDRESS <i>Forest Hill, Maryland</i> DATE SIGNED <i>2-6-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>Feby 7/56</i> NAME OF CEMETERY OR CREMATORIUM <i>Friends Burying Grounds</i> LOCATION (City, town, or county) <i>2506 HARFORD Road</i> (State) <i>BALTIMORE MD</i>	
24. REC'D BY REGISTRAR DATE <i>2-6-56</i>		REGISTRAR'S SIGNATURE <i>Purcella Foword</i> 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Joseph T. Smith Belair Md.</i>	

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: This requires that the death certificate be executed within 24 hours after death.
FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

This bottom copy may be retained by the hospital or attending physician.

VS AISC 1-55 10W



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

01839-

Reg. Dist. No.

1827

1. PLACE OF DEATH a. COUNTY HARFORD		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE de GRACE		c. LENGTH OF STAY IN 1b 12 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE de GRACE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp.		d. STREET ADDRESS 617 Juniper St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Dolores	Middle Scillli	Last February 28 1956	4. DATE OF DEATH Month February	Day 28	Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/7/1897	9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY wore		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rovanna Di Annunzio		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Mrs. Robert Whitney, Ontario St., Harford, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Arteriosclerosis Hypertension					
DUE TO (c)		Diabetes Mellitus					
DUE TO (c)		Mall Bladder & rectum					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 27, 1956 , to Feb. 28, 1956 , that I last saw the deceased alive on Feb. 28, 1956 , and that death occurred at 745 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Charles J. Foley M.D.						ADDRESS (Street, city or town, state) Harford Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/56		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion		22d. LOCATION (City, town, or county) (State) Harford Grace, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James J. Hanrahan, Harford, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE Mar. 3-56		24b. REGISTRAR'S SIGNATURE A. L. Lewis, M.D.	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

B. 1000 A. 9

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MARYLAND STATE DEPARTMENT OF HEALTH

01840

1856 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 180

1. PLACE OF DEATH: COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania		COUNTY Delaware	
CITY (If outside corporate limits, write RURAL and give nearest town) Abingdon		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Lansdowne		(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		104 Mc Kinley Ave.,			
3. NAME OF DECEASED (First) Elwood T. Sterling (Middle)		(I. & C.)		4. DATE OF DEATH February 24 1956		(Year)	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Mar. 3, 1908	9. AGE last birthday 47 yrs.	If under 1 year Months	If under 24 hrs Days	Hour Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY contractor		11. BIRTHPLACE (State or foreign country) Bloomsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Jennie Sterling		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 194-07-8982	
17. INFORMANT AND ADDRESS Jennie Sterling, Bloomsburg, Penna.,		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION		INTERVAL BETWEEN ONSET AND DEATH	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

2.1 Immediate cause

(a) Poisoning due to carbon monoxide

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING =	PLACE (Home, farm, factory, street, office bldg., etc.) Field	CITY OR TOWN Abingdon	(COUNTY) Harford	(STATE) Md.
CAUSE OF DEATH.	INJURY	HOW DID INJURY OCCUR?		
TIME (Month) (Day) (Year) (Hour) OF INJURY 2/24/56	INJURY OCCURRED While at m. work <input type="checkbox"/>	Not while at work <input checked="" type="checkbox"/>	Blow from auto exhaust into car	

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes accident , suicide , homicide , undetermined .

SIGNATURE

(Degree or title) ADDRESS

DATE SIGNED

Harold C. Palmer MD Deputy Medical Examiner Bldg Atr 11 2/24/56

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2/25/1956	NAME OF CEMETERY OR CREMATORIAL Baker Funeral Home	LOCATION (City, town, or county) Bloomsburg, Columbia	(State) Pa.
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DATE REC'D BY LOCAL REG. OFFICER REG. OFFICER'S SIGNATURE Feb 28, 1956 Norma G. Moore

24. FUNERAL DIRECTOR ADDRESS Edward K. McComas & Son, Abingdon Md.

Howard R. McComas Jr.

BURGESS

1000



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A1SC 1-35 10M
The bottom copy may be retained by the hospital or attending physician.
The third copy should be detached for use as a burial transit permit.

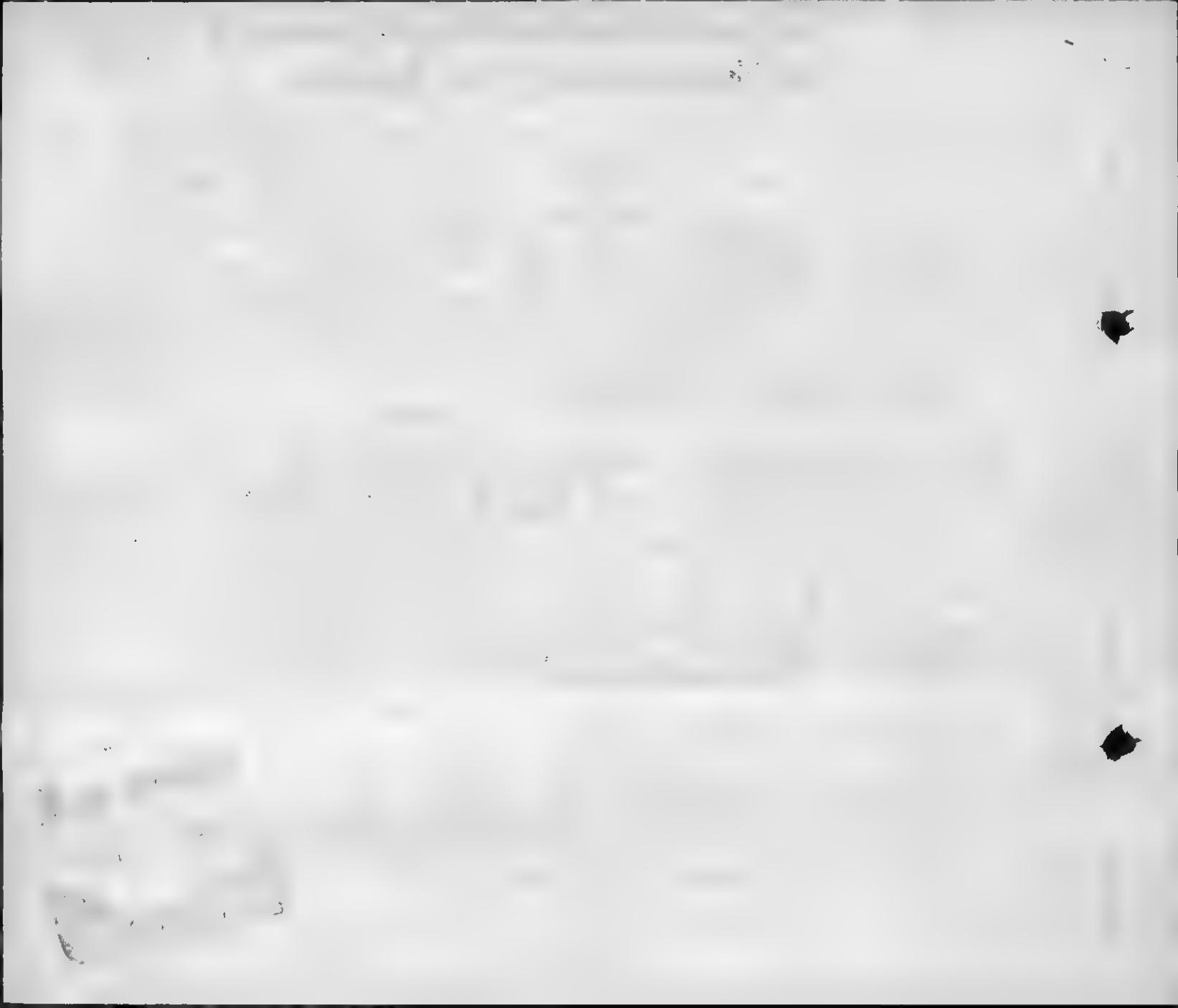
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01841

Reg. Dist. No. 180

1838 CERTIFICATE OF DEATH

1. PLACE OF DEATH HARFORD COUNTY		MARYLAND MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED MARYLAND STATE	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HARVE DE GRACE		LENGTH OF STAY (in this place) 3 months		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN PERRYMAN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD MEMORIAL HOSPITAL		STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (Type or Print) MARY S. TAYLOR		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year) February 1 1956	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH 4-2-1878	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Deyrs Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - Home		11. BIRTHPLACE (State or foreign country) N. J.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOSEPH W. TAYLOR		14. MOTHER'S MAIDEN NAME ANNA E. STOCKHAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. —		17. INFORMANT & ADDRESS Son Lynn T. Friney Jr. Aberdeen Md.	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 445X IMMEDIATE CAUSE		INTERVAL BETWEEN ONSET AND DEATH 42 hrs.			
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO		Vascular collapse (post-operative)			
(B) DUE TO		Hypertensive cardio vascular disease			
(C) DUE TO		Tumor of rectum			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION 1-30-56		19b. MAJOR FINDINGS OF OPERATION Tumor of rectum		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 330 S. Union Ave, Havre de Grace, Md.		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) 330 S. Union Ave, Havre de Grace, Md. 2-1-56	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-2 1955 , to 2-1 1956 , that I last saw the deceased alive on 2-1 1956 , and that death occurred at 3:00 p.m. from the causes and on the date stated above.					
ADDRESS (Street, city, town, state) 330 S. Union Ave, Havre de Grace, Md. 2-1-56					
DATE SIGNED 2-1-56					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/4/56		NAME OF CEMETERY OR CREMATORIAL Spectra Cemetery	
24. REC'D BY REGISTRAR John G. Barringer		REGISTRAR'S SIGNATURE John G. Barringer		LOCATION (City, town, or county) Perryman, Maryland	
DATE Feb 4 1956				ADDRESS Aberdeen, Maryland	
25. FUNERAL DIRECTOR'S SIGNATURE John G. Barringer					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01842

Reg. Dist. No.

1839

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARVE DE GRACE	c. LENGTH OF STAY IN 1b 9 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Aberdeen Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp.		d. STREET ADDRESS ABERDEEN Maynard Rd.	
3. NAME OF DECEASED (Type or print) Annie	First	Middle	4. DATE OF DEATH Month Day Year February 26 1956
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/25/1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY at Home	11. BIRTHPLACE (State or foreign country) MARYLAND BALTO U.S.A.
13. FATHER'S NAME J. Clinton Cooke		14. MOTHER'S MAIDEN NAME Lucy Dunn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ✓		16. SOCIAL SECURITY NO. -	17. INFORMANT Mr Francis E. Vermillion, R.F.D. 1, Aberdeen, Md.
			Address Maynard Rd., Aberdeen, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to Acute Pancreatitis		INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-9-1956 to 2-15-1956, that I last saw the deceased alive on 2-15-1956, and that death occurred at 3:15 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE JAMES MCC. FINNEY	M.D. ADDRESS (Street, city or town, state) 330 S. Union Ave., Harford Grace, Md.		DATE SIGNED 2-21-56
PHYSICIAN'S NAME (Type) JAMES MCC. FINNEY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/29/56	22c. NAME OF CEMETERY OR CREMATORIAL New Balto, National	22d. LOCATION (City, town, or county) Frederick Ave
23. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan	ADDRESS 90 Hollins St.	24a. REC'D DAY REGISTRAR DATE 2/28/1956 Dr. L. Johnson	24b. REGISTRAR'S SIGNATURE

Manual V. 8

FEB 11 1983

100-200-300-400

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01843

1857

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

COUNTY HARFORD

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)LENGTH OF STAY
(in this place)

TOWN CARDIFF

28 YRS.

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS3. NAME OF
DECEASED:
(Type or Print)

WILLIAM HENRY WELCH

(Middle)

(Last)

4. DATE (Month)
OF
DEATH: FEB. 15,(Day) (Year)
1956

5. SEX:

M

6. COLOR OR
RACE: W7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(S.M.W.D.)

8. DATE OF BIRTH:

JUNE 10, 1887

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):

AMMUNITION LOADER

10B. KIND OF BUSINESS
OR INDUSTRY: U.S. GOVT.

13. FATHER'S NAME:

THOMAS WELCH

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, No, or unk.) (If Yes, give war or dates
of service)

16. SOCIAL SECURITY NO.

No

215-03-0428

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4/15/56

IMMEDIATE CAUSE

(A)
DUE TO

Nephritis

ANTECEDENT CAUSE (S)

(B)
DUE TODISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

Arterio sclerotic C-V Disease

INTERVAL BETWEEN
ONSET AND DEATHII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

Coronary Thrombosis

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
While Not while
at work at work

21F. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from 4/15/56 to Feb 15, 1956, that I last saw the deceased
alive on Feb. 15, 1956, and that death occurred at 5:30 P.M., from the causes and on the date stated above.
SIGNATURE: *Frank A. Hunt, M.D.*

ADDRESS

DATE SIGNED

2/17/56

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

BURIAL

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

2/18/56

REGISTRAR'S SIGNATURE

Ruthella Lowwood

24. FUNERAL DIRECTOR

JOHN H. HARKINS, DELTA, PA.

Y' A OUVERTE

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01844

1840 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town)	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY HARFORD (If rural give location)
TOWN HAVERDE GRACE	50 YRS	TOWN HAVERDE GRACE	515 FOUNTAIN ST.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 515 FOUNTAIN ST.			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH FEB. 7 1956	
(First)	(Middle)	(Last)	
MAZEL SYDONIA WHITEHEAD			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH JAN. 16, 1879
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE last birthday 77 yrs.
		11. BIRTHPLACE (State or foreign country) MD	
13. FATHER'S NAME GEORGE F. LYDAIRD		14. MOTHER'S MAIDEN NAME SISANNA M. WATKINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. —	
		17. INFORMANT & ADDRESS MR. GUSTAVUS WHITEHEAD	
18. MEDICAL CERTIFICATION HAVERDE GRACE, MD. INTERVAL BETWEEN ONSET AND DEATH X IMMEDIATE CAUSE (A) <i>Hemiplegia - Cerebral Hemorrhage</i> ANTECEDENT CAUSE(S) DUE TO (B) <i>Chronic I. D. Disease Unphated</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M		White <input type="checkbox"/> at work <input type="checkbox"/>	Not white <input type="checkbox"/> at work <input type="checkbox"/>
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 3</u>, 1956, to <u>Feb. 7</u>, 1956, that I last saw the deceased alive on <u>Feb. 7</u>, 1956, and that death occurred at <u>77</u> M. from the causes and on the date stated above. SIGNATURE <i>John J. Lewis</i> ADDRESS (Street, city, town, state) <i>Harde Grace, Md.</i> DATE SIGNED <u>2/9/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE HEREON FEB. 10, 1956	NAME OF CEMETERY OR CREMATORIUM Ivy Hill Cem.	LOCATION (City, town, or county) PRINCE GEORGE Co., MD. (State)
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE L. T. Lewis / R. Madison Mitchell HAVRE DE GRACE, MD.		
DATE Feb. 4, 1956	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1858

CERTIFICATE OF DEATH

01845

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa		c. LENGTH OF STAY IN 1b 36		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Amelia	Middle	Last Willick	4. DATE OF DEATH	Month Feb.	Day 18	Year 1956
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 15, 1882	9 AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Strums Schaefer		14. MOTHER'S MAIDEN NAME Cathie Fink					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT William H. Willick		Address Joppa, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				<i>Cicute pulmonary edema</i> <i>arterio-occlusive disease of the heart 10 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>weakness</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>fall</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Churchville		20f. (City or town) Churchville	(County) Maryland
21. I certify that I attended the deceased from June , 19 56 , to Feb. , 19 56 , that I last saw the deceased alive on 1st 18 1956 , and that death occurred at Churchville , Maryland, from the causes and on the date stated above.						DATE SIGNED Ralph Horkey	
ACTUAL SIGNATURE <i>J. Ralph Horkey</i>		PHYSICIAN'S NAME (Type) J. Ralph Horkey		ADDRESS Abingdon		ADDRESS (Street, city or town, state) Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 21, 1956		22c. NAME OF CEMETERY OR CREMATORIUM St. Stephens		22d. LOCATION (City, town, or county) Bradshaw, Balto.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCormas & Son		ADDRESS Abingdon		24a. REC'D BY REGISTRAR DATE Feb 22, 1956		24b. REGISTRAR'S SIGNATURE Norma Moore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1005
B

A 1005

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be exhibited within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VIS AUS 155 10M
The bottom copy may be retained by the hospital or attending physician.
The certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01846

CERTIFICATE OF DEATH

1841

Reg. Dist. No. 185

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY HARFORD	MARYLAND	STATE Maryland	COUNTY HARFORD
CITY (If outside corporate limits, write RURAL OR end give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN HAURE DE GRACE	6 HRS.	TOWN ABERDEEN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD Memorial Hosp	STREET ADDRESS 203 S. ROGERS		
3. NAME OF DECEASED (First) (Middle) (Last) CHARLES OSCAR WOLTERSBERGER		4. DATE (Month) (Day) (Year) February 1 1956	
S. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH June 22-1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B&O Railroad		10b. KIND OF BUSINESS OR INDUSTRY Turner Dept.	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
13. FATHER'S NAME CHARLES WOLTERSBERGER		14. MOTHER'S MAIDEN NAME GERTRUDE PARKS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) unk.		16. SOCIAL SECURITY NO. —	
17. INFORMANT & ADDRESS 8th St. Aberdeen Md.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 33IX IMMEDIATE CAUSE		INTERVAL BETWEEN ONSET AND DEATH 7 hours	
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Acute Hypertensive Crisis		DUE TO (A) Cerebro-Vascular Accident	
		(B) Gen. Arteriosclerosis with BP 260/160	
		(C) 5 years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		19a. DATE OF OPERATION	
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) BEL AIR, MD		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Feb 1 1956 10:00 AM		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		1956 Jan 31 1956	
22. I hereby certify that I attended the deceased from Jan 31 1956 and that death occurred at 12:45 PM , from the causes and on the date stated above. SIGNATURE A. Sandeehi MD			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial New Govt.		DATE THEREOF 2/2/56	
24. REC'D BY REGISTRAR John Lewis M.D.		NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery	
DATE Feb 4 1956		LOCATION (City, town, or county) Nothwood Perma	
REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE John G. Tarrin Aberdeen Md.	
ADDRESS		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-2 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01847

1842 CERTIFICATE OF DEATH

Reg. Dist. No. 183-

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Cecil</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Port de Grace</i>	LENGTH OF STAY (in this place)	TOWN <i>Port de Grace</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Port de Pointe</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial Hosp</i>		STREET ADDRESS <i>Port de Pointe</i>	(If rural give location) <i>Md.</i>
3. NAME OF DECEASED (Type or Print) <i>Archie Mathews Wolford</i>		4. DATE (Month) OF DEATH <i>Feb. 4 1956</i>	
SEX <i>F</i>	COLOR OR RACE <i>W</i>	SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	DATE OF BIRTH <i>3-20-1877</i>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	AGE last birthday <i>78</i>
13. FATHER'S NAME <i>Daniel Lumbarger</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>14-10-0000</i>	
17. INFORMANT & ADDRESS <i>Mr. T. Wolford, Post Deposit, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 IMMEDIATE CAUSE <i>Stroke vascular accident</i>			
ANTECEDENT CAUSE(S) DUE TO <i>Arteriosclerotic Cardiovascular Disease</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Tumor at adrenal (pheochromocytoma)</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <i>2</i>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>House de Grace</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>Feb. 4 1956 10 P.M.</i>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <i>House de Grace</i>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Stroke</i>	
22. I hereby certify that I attended the deceased from 19 to 19 , that I last saw the deceased alive on <i>Feb. 4, 1956</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>John K. Prender</i> M.D. ADDRESS (Street, city, town, state) <i>House de Grace</i> DATE SIGNED <i>2-4-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2-7-1956</i>	NAME OF CEMETERY OR CREMATORIUM <i>Round Hill Marion, Va</i>
24. REC'D BY REGISTRAR <i>A. L. Lewis</i>		REGISTRAR'S SIGNATURE <i>A. L. Lewis</i>	LOCATION (City, town, or county) <i>Marion, Va</i>
DATE <i>Feb. 6-1956</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>G. L. Lewis and A. Patterson & Son Perryville Md</i>	

AT THE STATE OF MASSACHUSETTS,

THE GOVERNOR'S OFFICE,
COMMONWEALTH OF MASSACHUSETTS,

BUREAU V. S.

FEB 7 1956

RECEIVED